Letters to the Editor

Possible Manic Phase Precipitated by Antidepressant Treatment

Sir: I read with interest the December 1999 "Diary From the Front Lines" column by Christian G. Wolff, M.D.[1] I wonder if Dr. Wolff considered that his Wednesday patient, BT, might have cyclothymia or bipolar illness. The patient's excessively loud speech might not be from hearing problems but rather be similar to the typical pressured speech associated with the aforementioned disorders. I believe I have seen this several times in the past. In addition, since the patient's buddies now refer to BT as "Mr. Sunshine," I was suspicious that the unopposed treatment with the antidepressant sertraline without a mood stabilizer might have precipitated a mild manic phase of bipolar illness, uncovering the true diagnosis serendipitously. Perhaps not, but the vignette raised both my suspicion and my curiosity.

Reference

1. Wolff CG. Travel itineraries, jackhammers, and acorns [Diary From the Front Lines]. Primary Care Companion J Clin Psychiatry 1999;1:191–192

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Dr. Wolff Replies

Sir: Dr. Smith raises an interesting and excellent point. As part of BT's annual physical, I obtained audiometry data that supported bilateral sensorineural hearing loss (again, he is a lifelong road construction worker exposed to jackhammers, bulldozers, etc.). As far as hypomania is concerned, I have seen him in follow-up for other incidental items during the interim (sniffles), and he appears to be quite even-keeled. I appreciate Dr. Smith's comments, for they raise an excellent point to consider when evaluating such patients.

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Gabapentin in the Treatment of Aggression Associated With Conduct Disorder

Sir: In this case report, we describe a patient with a DSM-IV diagnosis of conduct disorder resulting in aggression and violent behavior whose symptoms were controlled with gabapentin after he had failed a trial of divalproex sodium. There is one previously published report[1] of gabapentin in the treatment of mania, but we found no cases describing its use in aggression related to conduct disorder.

Case report. Mr. A, a 17-year-old adolescent boy, was admitted to a children's home in September 1997 owing to multiple offenses including endangering the welfare of a minor, resisting arrest, petty larceny, and criminal mischief. He was first seen in psychiatric consultation because of aggressive behavior and physical assault; the last episode involved a police officer. Mr. A gave a history indicative of poor impulse control, indicating "I act first and think later." He reported getting into altercations that he realized he should have refrained from and that his response to situations was out of proportion to the provocation and was at times even unprovoked. He also gave a history of easy irritability and explosivity. His past psychiatric history revealed one previous psychiatric hospitalization after a fight with the police. Past medical history revealed a closed head injury with loss of consciousness for 4 hours following a fight with the police. There was no history of seizure disorder. He had drunk alcohol twice in his life and had never used drugs. Mr. A had no contact for many years with his biological father. School records from testing done in 1993 indicated a verbal IQ of 95, performance IQ of 108, and a full-scale IQ of 94. His mathematics and English skills were at the seventh- and ninth-grade level, respectively. Legal history was significant for 12 felonies, including armed robbery and drug trafficking, and he had been incarcerated approximately 5 times. Mr. A also admitted to stabbing a sixth grader multiple times. The initial diagnosis was intermittent explosive disorder, with bipolar disorder NOS in the differential diagnosis. Owing to the history of head injury, temporal lobe syndrome cannot be ruled out, despite one normal sleep-deprived electroencephalogram (EEG).

Mr. A underwent a complete medical workup that included laboratory studies, a computed tomographic scan of the brain, and sleep-deprived EEG. All test results were unremarkable. He was started with divalproex, 500 mg twice daily, which was then titrated to a total dosage of 2000 mg in divided dosages (serum level = 91.2 μg/mL), in an effort to address target symptoms such as unprovoked aggression, impulsivity, and explosivity. Because of continuing sleep disturbance, trazodone was added in a dosage of 50 mg at bedtime and was increased to 75 mg. He continued community service at this time and continued to be assaultive to peers and others in an unpredictable fashion. He continued to report racing thoughts and sleep disturbance. He took divalproex for a total duration of 7 months and took the 2000-mg/day dosage for the last 3 months prior to hospitalization. Mr. A developed increasing depressive symptoms and was prescribed fluoxetine, 10 mg daily, but subsequently was hospitalized owing to suicidal ideation stemming from his concern that he was going to spend the rest of his life in prison.

Mr. A returned from the hospital on treatment with a combination of multiple medications, which included gabapentin, 400

mg q.i.d.; risperidone, 2 mg h.s.; bupropion sustained release, 150 mg t.i.d.; and amantadine, 100 mg b.i.d. He was switched to gabapentin owing to lack of response to divalproex. He reported that he was "doing really well," without any racing thoughts, and his sleep pattern had improved. The discharge diagnosis was major depression without psychotic features and conduct disorder, childhood onset. No further aggressive episodes were reported. Mr. A was tapered off the amantadine and risperidone without any increase in aggression. He had been taking gabapentin for a total of 3 months prior to discharge from the children's home and had been free of aggressive episodes for that time frame.

This case describes a teenager with a DSM-IV diagnosis of conduct disorder who had comorbid diagnoses of bipolar disorder, major depression, and intermittent explosive disorder. Gabapentin was found to be effective when used to treat target symptoms such as unprovoked aggression, impulsivity, and explosivity. His symptomatology was complex, which made the case a diagnostic challenge. In addition to conduct disorder, symptoms included depression, manic-type symptoms, and explosive symptoms. Gabapentin was clearly efficacious in controlling the irritability, mood swings, impulsivity, and aggression. Limitations of this case study are the use of adjunctive medications such as bupropion with gabapentin and fluoxetine with divalproex and the initial use of risperidone with gabapentin.

There is one previous report[1] of gabapentin used successfully in an adolescent manic patient who failed a trial of divalproex. That patient had comorbid attention-deficit/hyperactivity disorder, unlike our patient, who had conduct disorder and a complex comorbid symptomatology. Several reports describe the use of gabapentin in mania in adults.[2–5] We found no reports describing the use of gabapentin in patients with severe conduct disorder. Lithium carbonate, divalproex, and antipsychotics have been used extensively in patients with conduct disorder who have severe aggression.

This case suggests that gabapentin is a valuable option because of good tolerability, safety in overdose, and good symptom control. The pharmacokinetic profile of gabapentin offers several advantages over other antiepileptic agents such as absence of serum protein binding and the absence of hepatic metabolism. It is eliminated unchanged by the kidneys. Drug-drug interactions with other antiepileptic drugs and other medications, such as oral contraceptives, appear nonexistent. In the primary care setting, gabapentin is a relatively safe drug to use because of its safety in overdose and lack of need of frequent blood levels for monitoring (unlike divalproex). In adults, the dosage range of gabapentin is 600 to 4800 mg/day, whereas in children, the suggested dosing is 10 to 30 mg/kg/day given in 3 divided dosages. Controlled studies are needed to further establish these findings.

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Citalopram and Hair Loss

Sir: Selective serotonin reuptake inhibitors (SSRIs) are the mainstay of treatment for a wide variety of psychiatric disorders including mood and anxiety disorders. Hair loss with the SSRIs, tricyclic antidepressants (TCAs), and other classes of antidepressants has been anecdotally reported.[1–6] We report a case of a 50-year-old white woman with bipolar disorder who developed hair loss while taking the SSRI citalopram. Significant hair loss can be a distressing side effect of antidepressants and should be monitored in treatment because it may lead to noncompliance and relapse.

Case report. Ms. A, a 50-year-old divorced white woman with a DSM-IV diagnosis of bipolar disorder, is presently in outpatient treatment at a community mental health clinic. Her past psychiatric history was significant for multiple hospitalizations for both manic and depressive episodes. There was no prior history of suicide attempts, nor was there any comorbid alcohol or substance abuse. She had no significant ongoing medical problems. Her last psychiatric hospitalization was in August 1997, for depressive symptoms and suicidal ideation. At that time, she had lithium-related side effects and had poor tolerance to divalproex and carbamazepine. Results of her laboratory tests, including a complete blood count, electrolyte concentrations, liver and kidney tests, and thyroid hormone studies, were unremarkable. During her last hospitalization, she was started successfully on lamotrigine therapy and titrated to a dosage of 50 mg twice daily. In addition, she was treated with paroxetine, 20 mg daily, and clonazepam, 0.5 mg in the morning and 1 mg at night. Following discharge from the hospital, her compliance with the medication and outpatient visits was good.

Treatment with clonazepam was subsequently successfully discontinued. One year later, owing to worsening depression, the paroxetine dosage was gradually increased to 40 mg daily on an outpatient basis. She then reported nightmares and continuing depressive symptoms. The patient was gradually switched to citalopram, which was started at 20 mg and then titrated to 40 mg with good symptom control. At her next visit a couple of months

later, the patient reported losing clumps of hair while shampooing. She became increasingly anxious at this time and was placed on hydroxyzine, 25 mg 3 times daily. A dermatology consultation was obtained to rule out other causes of hair loss, but none were detected. As the hair loss appeared temporally related to the increase in citalopram dosage, the possibility of dosage reduction was considered, but the patient was reluctant because of good symptom control. A multivitamin formulated for adults aged 50 and over (Centrum Silver) was added in a dosage of 1 tablet daily with the provision that the antidepressant be switched if the hair loss persisted at the next visit 4 weeks later. The hair loss stopped with Centrum Silver use, and there have been no complaints about it for the past 5 months as the patient continues to monitor the condition. The patient remains compliant with all medications. There have been no side effects, such as the rash that has been reported with lamotrigine, nor has there been any recurrence of manic symptoms.

To our knowledge, this is the first case report of hair loss associated with citalopram therapy. Citalopram selectively inhibits the reuptake of serotonin (5-hydroxytryptamine), which potentiates serotonergic neurotransmission and is associated with clinical antidepressant effects.[7] In some cases, it appears that hair loss accelerates when the dose of the antidepressant is increased.[2,6] Hair loss with citalopram therapy may be reversible with adjunctive Centrum Silver. An alternative explanation could be spontaneous resolution of the hair loss independent of the use of Centrum Silver. Significant hair loss is a distressing side effect that should be monitored and treated since it can lead to noncompliance, worsening of symptoms, and relapse.

References

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